America's Health Insurance Plans

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October 31, 2014

Mike Kreidler
Insurance Commissioner
P.O. Box 40255
Olympia, WA 98504-0255

Re: Network Access Exposure Draft (R 2014-08)

Dear Commissioner Kriedler,

I write today on behalf of America's Health Insurance Plans (AHIP) to provide comments on the Washington Office of the Insurance Commissioner's (OIC) exposure draft of the network access rules.

AHIP is the national trade association representing the health insurance industry. AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs. Health plans have been committed to providing consumers with affordable products that offer robust networks of quality, cost-efficient providers. With this goal in mind, we offer the following comments.

Washington has had established network adequacy regulations for over a decade. In addition, the Affordable Care Act (ACA) Exchange Rule establishes network adequacy requirements to ensure all consumers have access to a broad array of physicians and hospitals in health plans' provider networks; and requires qualified health plans to maintain a network that is sufficient in number and types of providers. The Centers for Medicare and Medicaid (CMS) determined that Washington's network adequacy standards and reviews met ACA requirements[1], even before the 2013 amendments were made. Finally, in addition to state and federal standards, there are network adequacy standards required in order to meet National Committee for Quality Assurance (NCQA) and URAC accreditation.

AHIP and its members are very committed to ensuring that consumers have access to the best networks of providers available and believe standards already in existence by the state, the ACA, and accrediting organizations create beneficial consumer protections while allowing health plans flexibility to create quality, efficient networks. We are concerned that the exposure draft as

[1] Centers for Medicare and Medicaid Services. *Completing the Network Adequacy Portion of the QHP Application*. Available at: http://www.tdi.texas.gov/health/documents/QHPnetworkadqcy.pdf.

issued by the OIC would actually create a more active role for the department in provider contracting that could be detrimental to the process of provider negotiations and confidential discussions. We strongly encourage the OIC to recognize that the existing process is already working for consumers, and not proceed with creating requirements that would result in administrative challenges and delays, and confusing and unnecessary requirements that could impede the contracting process and ultimately harm consumers.

Health plans continue to create new and innovative provider contracting and service models that are changing the way care is delivered while addressing gaps in provider networks and gaps in quality of care. We encourage the OIC to consider the efforts undertaken by health plans regarding delivery system reforms and new alternative provider payment models. Health plans are seeking to provide consumers access to high quality, efficient providers with a greater focus on coordinated care systems and high-value networks. These innovative alternatives are also more cost effective than requiring plans to contract with every provider in an area – some of whom may not meet the plan's credentialing or quality standards. AHIP cautions against intrusive rulemaking that will stifle health plan innovation and harm their ability to adapt to consumers' needs.

AHIP provides the following comments and concerns on specifics of the exposure draft.

WAC 284-43-202 Maintenance of sufficient networks
The standards contained in this section incorporate an underlying assumption that a network which does not include all specialists is suspect. This assumption is misguided; and the required tracking of changes to a network will not demonstrate change in the adequacy in the network. Change does not necessarily jeopardize access.

In addition, the standards and metrics contained in this section do not represent standards any have seen used previously. We request clarification on how the percentage benchmarks were chosen for each data point, and the basis for that standard.

We suggest instead that the OIC require carriers to monitor networks based upon the adequacy standards contained within the existing network access rules. If the networks no longer meet those standards due to a reduction of the number of providers, then the OIC may require the carrier to submit an alternate access delivery request in accordance with WAC 284-43-220(3)(d).

WAC 284-43-225 Issuer recordkeeping – Provider networks
We understand the need for adequate recordkeeping, but the timeframes laid out in section (1) need more clarification of when the timeframes for retention begin to run, specifically whether it is measured at the beginning or the end of the contract. Many issuers have long-standing provider contracts in place which may span longer than the ten year time period laid out in this section.

We understand that the provision that requires the tracking of the number of prior authorization requests and denials by benefit year is not related to network access, but is intended to help determine trends across health plans in this area. However, we note the classification of services requiring a prior authorization varies from issuer to issuer. Some may identify specific services; some may not require it at all. Thus, the OIC would be unable to glean trends from this data without an adequate baseline, and would have to adjust for differences in the requirements across all plans. We suggest this is an invalid measurement of trends, and should not be used.

Instead, we point the OIC to the existing methods of oversight of trends already collected by issuers and made available to the OIC per RCW 48.43.530, where in 10(a) each issuer must track each appeal until final resolution; maintain, and make accessible to the commissioner for a period of three years, a log of all appeals; and identify and evaluate trends in appeals.

WAC 284-43-320 Provider contracts – Standards – Hold harmless provisions

The requirement in section (8) that issuers require providers and facilities to cooperate with audit reviews of encounter data in relation to the administration of health plan risk adjustment and reinsurance programs is unnecessary and could provide complications with existing provider contracts. Provider contracts usually contain a provision requiring providers to comply with all audits. Such blanket audit provisions have been used to encompass necessary audits. A requirement to specify audits for the risk adjustment and reinsurance programs could cause complications because these programs are very new and long-standing provider contracts might not currently specify those programs. Provider contracts are incredibly complex and long-negotiated and, therefore, very difficult to re-open and amend. We recommend that maintaining current language regarding cooperation with audits is sufficient to address this concern.

WAC 284-43-330 Participating provider – Filing and approval

We suggest that the 30 day filing deadline for provider and facility agreements in section (1) be amended to read 30 days "prior to use" instead of "prior to the date that the contract is proposed for execution." This change will allow for situations in which a new party may be joining an agreement that has already been executed to be included.

The requirement in (6) that issuers file reimbursement agreements that are tied to health outcomes, utilization of specific services, patient volume, or other performance standards is duplicative with the already-existing requirement that carriers file all reimbursement agreements. If these are the specific types of agreements that the OIC seeks, then the other blanket filing requirements should be repealed. We are also concerned with the requirement that issuers identify the number of enrollees in the agreement's service area. For new agreements, this number would be unknown and for existing agreements, enrollment would have to be estimated and it is unclear what would happen if an issuer estimated incorrectly. In addition, the deadline for this filing, that these agreements be filed 30 days prior to the effective date of the agreement, conflicts with the 30 day prior-to-execution deadline in section (1).

AHIP will continue to work to promote and provide a transparent, value-based health care system. Collaboration with the OIC, health care providers, and other stakeholders is critical to the overall goal of achieving an affordable and broad choice of health care options to Washingtonians. We appreciate the opportunity to provide comments and look forward to continued discussions with you on this important issue. If you have any questions, please do not hesitate to contact me at gcampbell@ahip.org (971-599-5379).

Sincerely,

Grace Campbell
Regional Director